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August 2, 2010

MEMORANDUM

TO: Legislative Oversight Committee Members
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
MH/DD/SAS Stakeholder Organizations
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
NC Assoc. of County DSS Directors

FROM: Dr. Craigan L. Gray

Leza Wainwright

SUBJECT: Implementation Update #77
TCM for IDD
Update on MH/SA TCM
CABHA Monitoring
CABHA Enrollment Workshop
PA for Medicaid Funded Services in Durham & Eastpointe LME
AMHC Authorization Changes to ECBH
Update on New PA Guidelines for Outpatient
NC START Annual Report
Income and Family Size Information
MOA Update
NEA Letter Update

Targeted Case Management for Individuals with Intellectual and Developmental Disabilities

Pending written approval from the Centers for Medicare and Medicaid (CMS), the new weekly rate for Targeted Case Management for individuals with intellectual and developmental disabilities (I/DD) is $62.26 per week with an anticipated effective date of August 1, 2010. The new service code is T1017**HE**. This service is reimbursed at a weekly rate based on the billing of at least one unit per week. The expectation is that in order to bill for that week, a minimum of 15 minutes of service is provided. Although this is the minimum service provision required for billing, case managers are expected to provide the amount of service that is needed by the individual. Case managers must document all service that is provided and include the amount of time spent during each contact in the progress note. This documentation of services will be used to substantiate the weekly rate for audit purposes.

The claims processing system will be updated with the new rates and code upon CMS notification. Providers have the option of holding claims with date of service on or after August 1, 2010 until the new weekly rate is activated.

Pending written CMS approval and the claims processing system updates, communication regarding claims submission will occur as follows:

- Posting on the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) website
- Email blast from HP Enterprise Services to providers
- Communication to be forwarded to the local management entities (LME)

Update on Mental Health/Substance Abuse Targeted Case Management

Mental Health/Substance Abuse Targeted Case Management (MH/SA TCM) was implemented effective with date of service July 1, 2010 with a weekly case rate of $81.25. The procedure code for MH/SA TCM is H0032 and the billing limit is one unit per week (Sunday through Saturday). Prior approval is required for this service. To bill this weekly case rate, the case manager must provide at least 15 minutes of case management activity per week (assessment, person centered plan (PCP) development, linkage/referral, monitoring). However, the case manager must provide all services necessary to meet the case management needs of the recipient. For audit and rate setting purposes, each contact must be documented, and documentation must include the amount of time spent during the contact. Please see the Division of Medical Assistance (DMA) Clinical Coverage Policy 8L (http://www.ncdhhs.gov/dma/mp/) for the full description of the service.

Enrollment

CSC will issue each certified and enrolled Critical Access Behavior Health Agency (CABHA) a statewide MH/SA TCM Medicaid Provider Number (MPN) until site-specific enrollment can be achieved (more information on site-specific enrollment will be provided in future communications). CSC will contact those CABHAs that have already enrolled to assist with the completion of an additional application addendum for a statewide MH/SA TCM MPN. CABHAs that have not yet enrolled must indicate on the enrollment application that they will be providing MH/SA TCM by checking, "Targeted Case Management for Mental Health and Substance Abuse," on the enrollment application. The downloadable enrollment application is available on the NCTracks website (http://www.nctracks.nc.gov).

Prior Authorization

On September 1, 2010, CABHAs may begin to request prior authorization for MH/SA TCM after receiving a MH/SA TCM MPN. Submission of authorization requests must follow one of two procedures:

1. CABHAs may submit a MH/SA TCM Attestation Letter (see attached) for those recipients who were seen under a Community Support (CS) authorization **IF** service provided to those recipients followed all the MH/SA TCM policy guidelines, including those for entry criteria and service provision. Providers must submit an Attestation Letter for each CS recipient. All fields on the Attestation Letter must be completed or ValueOptions will return the form as "Unable to Process." The Attestation Letter must indicate the "start date" of MH/SA TCM services under the new MH/SA TCM MPN. The earliest "start date" for MH/SA TCM is July 1, 2010. Providers must also indicate the date at which the client should be "discharged" for CS under the Community Intervention Service Agency (CISA) MPN. The earliest date of "discharge" for CS recipients is June 30, 2010. The Attestation Letter must be signed by the qualified professional case manager who provides services to the recipient. Upon receipt of the Attestation Letter, ValueOptions will end-date the CS authorization under the CISA MPN and begin the MH/SA TCM authorization under the new MH/SA TCM MPN. ValueOptions will end-date the MH/SA TCM authorization with the same end-date as the former CS authorization. **Note**: CABHAs may not submit Attestation Letters for recipients receiving CS from a different provider. CABHAs may not provide MH/SA TCM to a recipient receiving CS from another provider.

2. CABHAs may submit prior authorization requests for recipients new to case management services. These would be recipients who are not currently receiving the case management portion of Community Support Services. To request prior authorization for MH/SA TCM, providers must submit the ITR, PCP, and a signed service order. The CABHA should request prior authorization using the MH/SA TCM MPN on the ITR in the "Facility ID#" field. Authorizations will be made to the MH/SA TCM MPN and **NOT** to the CABHA MPN.

Claims Submission
System implementation for payment of the weekly rate for MH/SA TCM is expected to be completed by September 1, 2010. Providers should not submit claims for MH/SA TCM prior to September 1, 2010. In the interim weeks, providers may continue to provide and bill the case management component of CS, if authorized for a recipient under the CISA MPN.

MH/SA TCM claims will always be billed using the professional (CMS-1500/837P) claim type. For claims submission the National Provider Identifier (NPI) associated with the CABHA MPN will always be the "billing" number and the NPI associated with the MH/SA TCM MPN will always be the "attending" number. Providers must bill MH/SA TCM claims with dates of service that correspond with MH/SA TCM authorization dates. The billing limit is one unit per week (Sunday through Saturday).

When a claim is submitted for MH/SA TCM, HP Enterprise Services will automatically recoup any payments for CS during any week (Sunday through Saturday) that the MH/SA TCM procedure code is billed. Claims will be recouped from the original CISA billing MPN that provided the service. The weekly unit may not be billed for any week in which there was no contact with the recipient. Services reimbursed will be subject to audit and recoupment if policy requirements were not met for that week.

Critical Access Behavior Health Agency Monitoring: Outcome and Process Measures
The implementation of CABHA requirements is designed to improve the quality of care and likelihood of positive outcomes for consumers. CABHA-certified providers pass a rigorous review process in order to achieve that designation. In order to assure that CABHAs continue to meet quality-of-care and patient-outcome standards, an outcome-based monitoring protocol has been developed with input from consumers, families, CABHAs, and LMEs, including LME Medical Directors. The monitoring will address specific CABHA infrastructure requirements such as medical and clinical oversight and quality management and quality areas such as integration with physical health care and achievement of personal outcomes for consumers. The grid below lays out the general areas to be addressed and includes both outcome and process measures.

Monitoring Area	**Outcome Measures**	**Process Measures**
Personal Outcomes	Individuals/families served by a CABHA report they are: • Living in recovery • Achieving therapeutic outcomes • Contributing members of their communities • Experiencing reduced reliance on paid services and supports	The CABHA analyzes individuals' progress toward treatment goals and uses that information to drive PCP.
Medical Director	Individuals/families understand their medication therapy and the associated risks and benefits.	*The CABHA Medical Director provides oversight of the medical and clinical services in the CABHA.* 1. The medical director's area of practice is

Monitoring Area	Outcome Measures	Process Measures
	Individuals/families report receiving services that address their needs.	consistent with the approved areas of practice noted in the CABHA policy/rule. 2. The medical director's job description includes all elements per CABHA policy/rule and there is evidence that the medical director is performing all elements noted in the job description. 3. Payroll for the medical director's position indicates the proper amount of medical director time, per the caseload requirements outlined in policy. 4. The CABHA Medical Director reviews the needs of individuals with complex/high needs including those receiving multiple medications indicating polypharmacy concerns. The medical director assures that instances of individuals receiving medication from multiple locations is addressed and reduced. 5. The CABHA Medical Director ensures that services are delivered in a clinically appropriate manner.
Use of community based treatment services to address crisis needs	Crisis needs of individuals/ families are successfully addressed within community based treatment services.	The CABHA offers robust "first responder" services and, when more intervention is needed, refers individuals to crisis services and other alternative resources to prevent or divert them from emergency departments or state hospitals.
Patterns of Referrals	1. Individuals/families served by a CABHA indicate having a choice of providers. 2. Individuals/families are referred when appropriate services are not offered by the CABHA. 3. All needs of the individual/ family (not just behavioral health needs) are addressed as evidenced by linkage and referrals to community resources.	1. The CABHA refers individuals to other agencies when requested by an individual or when the PCP or assessments indicate need. 2. The CABHA refers individuals/families to other service providers when the CABHA does not have the medically necessary service available. 3. The CABHA links/refers individuals/families to community resources to address needs other than their behavioral health needs.
Quality Management Plan	Individuals show progress toward achievement in outcomes, safety, health and recovery.	The CABHA regularly analyzes both individual and aggregate data on incidents, complaints, recovery progress and other topics and uses the results to drive agency planning, improvement activities and

Monitoring Area	Outcome Measures	Process Measures
		PCPs.
Integration with Physical Health Care	Individuals/families served by the CABHA report that their physical health needs are addressed.	1. The CABHA ensures that the physical health needs of the individuals/families are addressed. 2. The CABHA medical staff consults and communicates with LME staff and primary care providers.
Core Services	Individuals have access to core services provided at the CABHA certified site.	The CABHA core services staff has specific experience, training and expertise with the continuum target population.

CABHA Enrollment/Authorization/Billing Seminars

Enrollment/Authorization/Billing seminars for CABHAs are scheduled for August 2010 at the sites listed below. Information presented at the seminars is applicable to all providers who have been certified as a CABHA or are in the process of certification.

Materials will be provided at the training though you are encouraged to review Implementation Updates #73, #75, #76, and #77 in preparation.

Pre-registration is required. Due to limited seating, registration is limited to two staff members per office. Unregistered providers are welcome to attend if space is available.

Providers may register for the seminars by completing and submitting the online registration form (http://www.ncdhhs.gov/dma/provider/seminars.htm) or providers may register by fax using the form attached (fax it to the number listed on the form). Please indicate the session you plan to attend on the registration form.

Sessions will begin at 9:00 a.m. and end at 12:00 noon. Providers are encouraged to arrive by 8:45 a.m. to complete registration. Lunch will not be provided at the seminars. **Because meeting room temperatures vary, dressing in layers is strongly advised.**

Date	Location
August 17, 2010	**Eastern Region** Southeastern Regional LME 450 Country Club Road Lumberton NC 28360
August 24, 2010	**Western Region** Pathways LME 901 South New Hope Road Gastonia NC 28054
August 31, 2010	**Central Region** Wake Commons Conference Room 100A 4011 Carya Drive Raleigh NC 27610

In addition, on-site provider visits will be provided by HP Enterprise Services upon request.

Medicaid enrollment questions may be directed to CSC at 1-866-844-1113

http://www.nctracks.nc.gov/provider/providerEnrollment/

Authorization questions may be directed to ValueOptions:

- 1-888-510-1150 – Medicaid
- 1-800-753-3224 – Health Choice

http://www.valueoptions.com/providers/Network/North_Carolina_Medicaid.htm

Medicaid claims questions may be directed to HP Enterprise Services at 1-800-688-6696 or 919-851-8888.

Authorizations Changes for DD TCM, Therapeutic Foster Care (TFC), Provisionally Licensed Providers: Albemarle Mental Health Center/East Carolina Behavioral Health LME Merger

East Carolina Behavioral Health (ECBH) and Albemarle Mental Health Center (AMHC) have merged. As of July 1, 2010, all authorizations for DD Case Management, Therapeutic Foster Care, and services provided by provisionally licensed providers for recipients that were previously enrolled with the AMHC will now be transferred to ECBH's MPN by ValueOptions.

All new prior authorization requests for services with effective dates July 1, 2010, and forward should be sent to ValueOptions with ECBH's MPN. As of September 1, 2010, if ValueOptions receives a request with the AMHC Medicaid Provider Number (MPN) they will return it as "unable to process."

Providers will need to bill through ECBH until these services are directly enrolled. For any provider not already set up to bill through ECBH for AMHC services please contact the ECBH Help Desk at 252-636-1510.

Prior Authorization of Medicaid-funded Mental Health, Developmental Disability, Substance Abuse (MH/ DD/SA) Services by The Durham Center and Eastpointe LME

As of September 20, 2010, Medicaid services for mental health, developmental disabilities, and substance abuse will be reviewed for prior authorization by The Durham Center and Eastpointe LME **for their respective catchment areas only**. All LMEs will continue to authorize State funded services as is their current practice.

As of the 20th of September 2010, all providers for recipients with eligibility within The Durham Center's catchment area (Durham County) will be required to submit requests for initial and concurrent authorization for mental health, developmental disabilities, and substance abuse services to The Durham Center for prior authorization. All providers for recipients with eligibility within Eastpointe's catchment area (Duplin, Lenoir, Sampson, and Wayne Counties) will be required to submit requests for initial and concurrent authorization for mental health, developmental disabilities, and substance abuse services to Eastpointe for prior authorization. This change will only apply to providers delivering services to **recipients with eligibility** in those catchment areas.

Eastpointe and The Durham Center each have an electronic web-based system that will allow for a seamless and very efficient means of requesting authorizations. This system is called "ProviderConnect." It should not be confused with ValueOptions web-based system that is also named the same.

Submission of prior authorization requests to The Durham Center can be done through The Durham Center's LME ProviderConnect web-based system or to their dedicated fax number at 919-560-7377. The Durham ProviderConnect system can be accessed via the LME website, www.durhamcenter.org.

Submission of prior authorization requests to Eastpointe can be done through Eastpointe's LME ProviderConnect web-based system or dedicated fax number at 910-298-7189. The Eastpointe ProviderConnect system can be accessed via the LME website, www.eastpointe.net.

Trainings on how to use the LME ProviderConnect systems as well as other related prior authorization topics will be done during the month of August. If you serve a consumer in one of the counties listed above, please make sure to sign up for the trainings via the LME websites.

- Eastpointe: http://www.eastpointe.net/providers/trainingcalendar/trainingcalendar.aspx
- The Durham Center: http://www.durhamcenter.org/index.php/provider/pcalendar

During the transition of service authorizations from ValueOptions to the appropriate LME, the goal is to ensure that recipients have no interruption in service. In order for a seamless transition, these guidelines must be followed:

- All active authorizations for all mental health, substance abuse, DD TCM, and CAP services as of September 19, 2010 will remain in effect.
- ValueOptions will keep and process all prior authorization requests with an effective date prior to September 19, 2010, and submitted prior to September 19, 2010.
- Effective September 20, 2010, providers for recipients with eligibility in the LME catchment areas should begin sending initial and concurrent requests to the appropriate LME for processing. LMEs can only begin accepting authorization requests received on or after September 20, 2010.
- For any prior authorization request already received by ValueOptions that has an effective service date of service September 20, 2010, or later which ValueOptions has already received but cannot process by close of business September 19, 2010, ValueOptions will forward the request and all provider-submitted supporting documentation to the appropriate LME (The Durham Center or Eastpointe) and notify the requesting provider.
- The respective LME will determine the date ValueOptions received the prior authorization request (by the ValueOptions date stamp), and this original date of receipt will be honored.
- After September 20, 2010, any request that is received by ValueOptions that should be processed by one of the LMEs will be forwarded to the LME and the provider will be notified.
- Effective September 20, 2010, any retroactive review request for recipients with eligibility in the LME catchment areas must be sent to the appropriate LME. **This includes requests for services provided prior to September 20, 2010.**
- Effective September 20, 2010, all CAP and DD TCM requests must be sent to the appropriate LME for processing.
- **Special Note for Inpatient Hospitals and Psychiatric Residential Treatment Facilities (PRTF):** All concurrent Inpatient and PRTF requests should continue to be sent to ValueOptions for recipients currently in care as of September 20, 2010 until the patient is discharged.
- Providers should submit requests for "additional units" to ValueOptions for processing if ValueOptions approved the initial or concurrent request originally. In other words, if a recipient with eligibility in the Durham Center or Eastpointe catchment areas needs the authorization of additional units for a request that was authorized by ValueOptions prior to September 20, 2010 that request for additional units should be sent to ValueOptions for processing. It is important that the request be clearly labeled as a request for "additional units" to ensure that it is processed appropriately by ValueOptions in a timely fashion.

All current DMA Clinical Coverage Policy guidelines and prior approval submission requirements will continue to apply. All providers, regardless of catchment area, must continue to use the same forms that are currently being used for prior authorization request to ValueOptions, including the ITR, PCP, ORF2, and CTCM.

Information about Mediation and Appeals

ValueOptions and the LMEs will be responsible for mediation and appeals of cases that each has reduced or denied. ValueOptions will still be responsible for all mediation and appeals of requests that ValueOptions has reduced or denied, even if the date of the mediation or appeal is after September 20, 2010.

Questions about maintenance of service (MOS) can be directed to the utilization review vendor (ValueOptions: 1-888-510-1150, The Durham Center: 919-560-7100, or Eastpointe LME: 1-800-913-6109) who made the reduction or denial decision.

Update on New Prior Authorization Guidelines for Outpatient Behavioral Health Service Providers, Provisionally Licensed Providers Billing "Incident to" a Physician or through the Local Management Entity, and Critical Access Behavioral Health Agency's Direct-Enrolled Licensed Professionals

Provisionally Licensed Professionals
As stated in the June 2010 Medicaid Bulletin and Implementation Update #73 and #76, effective July 1, 2010, prior authorizations for all outpatient services, with dates of services July 1, 2010, and forward, will be created for the "Attending Provider Name/Medicaid #" on the ORF2 form. Providers must enter the Attending MPN associated with the Attending NPI with which they will submit their claims (do not submit NPI on the ORF2). Prior authorization requests will no longer be made for group providers. This applies to all direct-enrolled licensed professionals.

Current authorizations for outpatient services remain in effect. This new guidance applies only when a recipient needs new or additional authorization for dates of service July 1, 2010, and forward. As a reminder, prior authorization is only required after the 26 unmanaged visits for children and 8 unmanaged visits for adults. [Note: as a result of action by the General Assembly, the 26 unmanaged visits for children will decrease to 16 unmanaged visits effective October 1, 2010.]

To ease the transition to the new authorization process, providers will only need to list the "Attending Provider Name/Medicaid #" on the ORF2 form. The "Billing Provider Name/Medicaid #" field is not required through December 31, 2010. ORF2s submitted without the "Attending Provider Name/Medicaid #" will be returned by ValueOptions as "Unable to Process."

If clinically appropriate, providers may submit up to three MPNs on the "Attending Provider" line on the ORF2. This will allow for "reserve" attending therapists for a recipient in addition to the primary attending therapist. Each provider MPN must be separated by a comma. All attending MPNs/providers listed will be authorized for identical service codes, frequencies, and durations if the service request is deemed medically necessary. An ORF2 could have up to three "attending providers" indicated and those MPNs may be for a direct-enrolled professional, an LME (for provisionally licensed), a physician (for "incident to"), and for any combination of these three provider types. No provider names need to be listed on the ORF2 when multiple MPNs are listed.

Provisionally Licensed Professionals Billing through a Local Management Entity
Provisionally licensed professionals who bill through the LME will continue to request prior authorization with the LME's MPN as the "attending provider" and should continue to bill through the LME.

To ease the transition to the new authorization process, providers will only need to list the "Attending Provider Name/Medicaid #" on the ORF2 form. The "Billing Provider Name/Medicaid #" field is not required through December 31, 2010. ORF2s submitted without the "Attending Provider Name/Medicaid #" will be returned by ValueOptions as "Unable to Process."

In this scenario, provisionally licensed providers do not need to list separate MPNs on the ORF2 for "reserve" therapists if all authorization requests are for provisionally licensed professionals billing under the same LME. In this scenario, the LME MPN only needs to be listed once on the "Attending Provider" line of the ORF2. However, if the "reserve" therapist is a direct-enrolled provider or a provisionally licensed therapist is the "reserve" therapist to a direct-enrolled provider, the direct-enrolled provider's MPN **AND** the LME MPN are both included and separated by a comma. An ORF2 could have up to three "attending providers" indicated and those MPNs may be for a direct-enrolled professional, an LME (for provisionally licensed), a physician (for "incident to"), and for any combination of these three provider types. All attending MPNs/providers listed will be authorized for identical service codes, frequencies and durations if the service request is deemed medically necessary. No provider names need to be listed on the ORF2 when multiple MPNs are listed.

Current authorizations for outpatient services remain in effect. This new guidance applies only when a recipient needs new or additional authorization for dates of service July 1, 2010, and forward. As a reminder, prior authorization is only required after the 26 unmanaged visits for children and 8 unmanaged visits for adults.

[Note: as a result of action by the General Assembly, the 26 unmanaged visits for children will decrease to 16 unmanaged visits effective October 1, 2010.]

Provisionally Licensed Professionals Billing "Incident to" a Physician
Provisionally licensed professionals who bill "incident to" a physician should request prior authorization with the MPN of the individual physician as the "attending provider." This individual physician MPN is the individual physician that the provisionally licensed professional practices "incident to."

To ease the transition to the new authorization process, providers will only need to list the "Attending Provider Name/Medicaid #" on the ORF2 form. The "Billing Provider Name/Medicaid #" field is not required through December 31, 2010. ORF2s submitted without the "Attending Provider Name/Medicaid #" will be returned by ValueOptions as "Unable to Process."

Current authorizations for outpatient services remain in effect. This new guidance applies only when a recipient needs new or additional authorization for dates of service July 1, 2010, and forward. As a reminder, prior authorization is only required after the 26 unmanaged visits for children and 8 unmanaged visits for adults. In this scenario, provisionally licensed providers do not need to list separate MPNs on the ORF2 for "reserve" therapists if all authorization requests are for provisionally licensed professionals billing "incident to" the same physician. In this scenario, the physician's MPN only needs to be listed once on the "Attending Provider" line of the ORF2. However, if the "reserve" therapist is a direct-enrolled provider or a provisionally licensed therapist is the "reserve" therapist to a direct enrolled provider, the direct-enrolled provider's MPN **AND** the MPN of the individual physician are both included and separated by a comma. An ORF2 may have up to three "attending providers" indicated and those MPNs may be for a direct-enrolled professional, an LME (for provisionally licensed), a physician (for "incident to"), and for any combination of these three provider types. All attending MPNs/providers listed will be authorized for identical service codes, frequencies and durations if the service request is deemed medically necessary. No provider names need to be listed on the ORF2 when multiple MPNs are listed.

Please see all "incident to" guidelines in the March 2009 Medicaid Bulletin.

Outpatient Services Provided in a CABHA by Direct-Enrolled Providers
Prior authorizations for all outpatient services, with dates of services July 1, 2010, and forward, will be created for the "Attending Provider Name/Medicaid #" on the ORF2 form. Providers must enter the attending Medicaid Provider Number (MPN) associated with the attending National Provider Identifier (NPI) with which they will submit their claims (do not submit NPI on the ORF2). Prior authorization requests will no longer be made for group providers. This applies to all directly enrolled licensed professionals.

If clinically appropriate, providers may submit up to three MPNs on the "Attending Provider" line on the ORF2 for "reserve" attending therapists for a recipient in addition to the primary attending therapist. Each provider MPN must be separated by a comma. All MPNs/providers will be authorized identical service codes, frequencies, and durations if the service request is deemed medically necessary. An ORF2 could have up to three "attending providers" indicated and those MPNs may be for a direct-enrolled professional, an LME (for provisionally licensed), a physician (for "incident to"), and for any combination of these three provider types. No provider names need to be listed on the ORF2 when multiple MPNs are listed.

All current authorizations for outpatient services provided under a CABHA will remain in effect. This new guidance applies only when a recipient needs new or additional authorization for dates of service July 1, 2010, and forward.

To ease the transition to the new authorization process, providers will only need to list the "Attending Provider Name/Medicaid #" on the ORF2 form. The "Billing Provider Name/Medicaid #" field is not required through December 31, 2010. ORF2s submitted without the "Attending Provider Name/Medicaid #" will be returned by ValueOptions as "Unable to Process." Authorizations will not be made to the CABHA MPN.

As a reminder, prior authorization is only required after the 26 unmanaged visits for children and 8 unmanaged visits for adults. [Note: as a result of action by the General Assembly, the 26 unmanaged visits for children will decrease to 16 unmanaged visits effective October 1, 2010.]

Provisionally Licensed Providers under a CABHA

A correction to guidance provided in Implementation Update #76 is provisionally licensed providers offering services under a CABHA may bill "incident to" a physician in the CABHA or may bill through the LME using "H codes." All current authorizations for outpatient services provided by provisionally licensed providers under a CABHA will remain in effect.

Provisionally licensed professionals who bill through the LME will continue to request prior authorization with the LME's MPN as the "attending provider" and should continue to bill through the LME. In this scenario, provisionally licensed providers do not need to list separate MPNs on the ORF2 for "reserve" therapists if all authorization requests are for provisionally licensed professionals billing under the same LME. In this scenario, the LME MPN only needs to be listed once on the "Attending Provider" line of the ORF2. However, if the "reserve" therapist is a direct-enrolled provider or a provisionally licensed therapist is the "reserve" therapist to a direct-enrolled provider, the direct-enrolled provider's MPN **AND** the LME's MPN are both included and separated by a comma. An ORF2 could have up to three "attending providers" indicated and those MPNs may be for a direct-enrolled professional, an LME (for provisionally licensed), a physician (for "incident to"), and for any combination of these three provider types. All attending MPNs/providers listed will be authorized for identical service codes, frequencies and durations if the service request is deemed medically necessary. No provider names need to be listed on the ORF2 when multiple MPNs are listed.

Provisionally licensed professionals who bill "incident to" a physician in a CABHA should request prior authorization with the MPN of the individual physician as the "attending provider." This individual physician MPN is an individual physician in the CABHA practice that the provisionally licensed professional practices "incident to." In this scenario, provisionally licensed providers do not need to list separate MPNs on the ORF2 for "reserve" therapists if all authorization requests are for provisionally licensed professionals billing "incident to" the same physician. In this scenario, the physician's MPN only needs to be listed once on the "Attending Provider" line of the ORF2. . However, if the "reserve" therapist is a direct-enrolled provider or a provisionally licensed therapist is the "reserve" therapist to a direct-enrolled provider, the direct-enrolled provider's MPN **AND** the MPN of the individual physician are both included and separated by a comma. An ORF2 could have up to three "attending providers" indicated and those MPNs may be for a direct-enrolled professional, an LME (for provisionally licensed), a physician (for "incident to"), and for any combination of these three provider types. All MPNs/providers will be authorized identical service codes, frequencies and durations if the service request is deemed medically necessary. No provider names need to be listed on the ORF2 when multiple MPNs are listed.

To ease the transition to the new authorization process, providers will only need to list the "Attending Provider Name/Medicaid #" on the ORF2 form. The "Billing Provider Name/Medicaid #" field is not required through December 31, 2010. ORF2s submitted without the "Attending Provider Name/Medicaid #" will be returned by ValueOptions as "Unable to Process."

Authorizations will not be made to the CABHA MPN.

As a reminder, prior authorization is only required after the 26 unmanaged visits for children and 8 unmanaged visits for adults. [Note: as a result of action by the General Assembly, the 26 unmanaged visits for children will decrease to 16 unmanaged visits effective October 1, 2010.]

North Carolina Systemic, Therapeutic, Assessment, Respite, and Treatment Program (NC START) Annual Report

NC START provides community based crisis prevention and intervention services for people with intellectual and developmental disabilities who experience crises due to mental health or complex behavioral health issues. There are six NC START clinical teams across the state; two teams per region. The clinical teams became fully

operational in January of 2009. In addition to the clinical teams, NC START includes three respite homes, one per region. Each respite home contains two designated emergency respite beds, and two planned respite beds.

The first NC START annual report was submitted to the DMH/DD/SAS and the Division of State Operated Healthcare Facilities (DSOHF) by the three regional NC START Directors. The report provides a summary of information regarding NC START activities during their first year of operation. The complete annual report can be found on the DMH/DD/SAS website on the Statewide Crisis Services page at http://www.ncdhhs.gov/mhddsas/crisis_services/index.htm

Income and Family Size Information

The Patient Protection and Affordable Care Act (PPACA), the national health reform legislation, will have significant impact on mental health, developmental disabilities and substance abuse services in the coming years. Many thousands of individuals will become Medicaid eligible under new guidelines which raise the income level for Medicaid eligibility to 133% of federal poverty and experts estimate that a large percentage of those new Medicaid recipients will have MH/DD/SA service needs.

We have looked at the income and family size data of the consumers we are currently serving with state funds to estimate how many of those individuals will become Medicaid-eligible under the new guidelines. We have discovered that the income and family size data currently in our system appears, in some cases, to be of questionable accuracy. We have a large number of consumers who have been reported to have zero income and an equally large percentage who have reported incomes of $999,999,999! We have a surprising number of families who have 99 members, as well.

In order to accurately estimate the future impact of PPACA, we must improve the quality and reliability of our income and family size data. To that end, we are requesting LMEs to work with their providers to **pay special attention to the income and family size information for every consumer served during the month of October, 2010**. Income and who should be counted in the family should be determined based upon the attached guidelines. The data collected on clients served in October 2010 will become the initial step for improved data integrity in the family income and size fields.

- LME health information managers will receive information at the North Carolina Health Information Management Association (NCHIMA) conference to be held August 4, 2010 in Raleigh.
- Tentatively, the month of September 2010 will be used as a training period so that the LME's can train their providers on updating this information.
- A convenience sample of all clients served during October 1-31, 2010 will be utilized.
- In order to utilize current existing data submission methods, the CDW record types of 11 for new admissions or 31 for updates for currently active clients will be used to collect the necessary data to sample income among clients served.
- The income and family size fields should be reported using the clarification of the annual family income and family size definition.
- For new admissions submit an 11 record to CDW with the consumer last served date field completed with a date during the time period October 1-31, 2010, making sure that the family size and income is reported as defined under the clarification for these data elements.
- For currently active clients served during the month of October 1-31, 2010 submit a 31 record to CDW with updated income and family size fields and the consumer last served date field in the date range of October 1-31, 2010

Memorandum of Agreement Update

Effective immediately, if a provider which is actively endorsed to provide a Medicaid funded behavioral health service in one LME area, makes a request to any LME for a signed Memorandum of Agreement (MOA) to render that service to recipients residing in the LME area, the LME to which the MOA request is being made must sign the MOA with the requesting provider. The LME will have ten business days to honor such a request.

The request by the provider must be made in writing, accompanied by an existing standard agreement for those services, and sent by return receipt/certified mail. The LME must respond in writing within the ten day time period with a signed MOA sent to the requesting provider by return receipt/certified mail.

The purpose of the MOA with the non-endorsing LME is to ensure that the provider and the LME acknowledge and document their respective roles and responsibilities regarding consumers from the non-endorsing LME's catchment area.

Should the provider believe that an LME has not complied with this guidance; the provider may contact the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. DMH/DD/SAS has statutory responsibility for the Department of Health and Human Services (DHHS) to ensure that LMEs comply with all appropriate statute, rule and policy, per NC GS 122C-151.4.

Per the current endorsement policy: "*When a Provider is determined to have met endorsement requirements, the Area Authority/County Program (LME) will send the Provider the standard Agreement (MOA) between the Area Authority/County Program and the Provider.*" At that time the provider and the endorsing LME (Area Authority/County Program) should have signed copies of existing MOA in their perspective files indicating that provider is endorsed at a specific site location for specific service(s) with a current signed agreement (MOA).

Recently, DHHS, as well as CMS, have received complaints from providers that LMEs are refusing to sign MOAs of an already enrolled DMA provider requesting to provide services in a nearby LME. Effective immediately, if an endorsed/enrolled provider presents a formal written request and provides a copy of an existing agreement to another LME to provide specific endorsed/enrolled services in the LME's catchment area for which the request is being made, that LME must honor the request by signing a new MOA with the service provider. The LME cannot deny the provider's request to have a signed MOA. The LME will have ten business days to present to the provider with a MOA for signature processing. If the LME fails or refuses to honor such request—this complaint should be submitted to either DMH/DD/SAS LME System Performance Team or to DMA for corrective action.

Note that nothing in this policy is designed to obviate the provider's obligation to obtain a new site/service specific endorsement from another LME if they begin operating from a new site. This policy only pertains to providers delivering services from an endorsed site outside of a LME's catchment area to consumers from that LME. If the provider is requesting endorsement for either a new site location and/or adding a new service at an existing site location, such a request would require a new endorsement and defer to the endorsement policy as currently is in place.

Notification of Endorsement Action Letter Update

The Notification of Endorsement Action (NEA) letter has been updated, please see the attached form.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@dhhs.nc.gov.

cc: Secretary Lanier M. Cansler
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